Diet Diary:

Day: _____ Hours between last nights meal and todays first meal:_____

am temp:_____ am heart rate: _____

Breakfast (time and types of foods)	
Lunch	
Dinner	
Snacks	
Water (amount)	
Other drinks (types and amounts)	
Exercise (activity, intensity, time)	
Any adverse symptoms (pain, headaches, brain fog, memory loss, dizzy, fatigue, etc.)	

Energy: Rate on a scale from 0-10 (0 being you can barely get out of bed and 10 high energy and ready for the day)

Average energy: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Hours of sleep night previous: _____

Notes / insights:

_____

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